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December 18, 2015

Andrew M. Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

RE: Final Rule with Comment Period: CMS-2328-FC/RIN 0938-AQ54 Medicaid Program: Methods for Assuring Access to Covered Medicaid Services (Vol. 80, No. 211, November 2, 2015)

Dear Mr. Slavitt:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our 43,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) final rule with comment on methods for assuring access to covered Medicaid services. The final rule requires states to submit plans to monitor access to care for Medicaid beneficiaries and establish new review procedures for proposed rate changes in the Medicaid fee-for-service program. It also establishes procedures that states must follow to ensure that beneficiary access to core services is not affected before CMS approves a state's plan to cut or restrict provider rates. This final rule is particularly important in light of a March Supreme Court decision in *Armstrong v. Exceptional Child Center Inc.*, which found that Medicaid providers cannot contest state-determined Medicaid payment rates in federal court.

The AHA is extremely disappointed that CMS chose to exclude all hospital services, except for labor and delivery, as a core service in this critical review process. Failing to include such services means states will be able to continue to ignore patient needs and cut funds for hospital services with little federal oversight. Such oversight is needed to help ensure access to the full spectrum of care for the vulnerable Medicaid population. **Toward that end, the AHA recommends that CMS expand the list of core services required of state access monitoring review plans to include hospital services. CMS could accomplish this in two ways:**



1. **CMS can respond to this final rule with comment by expeditiously reissuing the final rule to include hospital services; or**
2. **CMS could withdraw the final rule and reissue it as a proposed rule for public comment.**

Whichever option CMS chooses, it is vitally important that the agency take action. The Supreme Court’s decision in *Armstrong v. Exceptional Child Center Inc.* has dramatically changed the Medicaid provider payment environment for hospitals since the proposed rule was first issued four years ago. Our detailed comments follow.

ACCESS MONITORING REVIEW PLAN REQUIREMENTS

CORE SERVICES (SECTION 447.204 (5)). The AHA strongly recommends including hospital services in the core services that must be reviewed by the state at least once every three years. As it stands now, the final rule categorizes five services as core: primary care, physician specialist, behavioral health, pre- and post-natal obstetric (including labor and delivery), and home health. The only hospital services that would be considered are those related to labor and delivery.

CMS provides very little justification for the selection of the five services, stating, “We believe these services are both in high demand and commonly utilized by Medicaid beneficiaries...” These remarks suggest that inpatient and outpatient hospital services are neither in high demand nor commonly utilized. Yet, the Agency for Healthcare Research and Quality (AHRQ) cites that, in 2012, out of the 36.5 million hospital inpatient stays in America, 20.9 percent were paid for by Medicaid.¹ Indeed, this statistic likely understates today’s percentage, as it predates the 2014 Affordable Care Act expansion of Medicaid. Looking at AHRQ data from two early Medicaid expansion states, California and Oregon, inpatient utilization increased in the fourth quarter of 2014 compared to the fourth quarter of 2013 by approximately 35 percent and 70 percent, respectively.²

CMS’s core services definition not only ignores the vital role hospitals play in ensuring access to health care services for Medicaid beneficiaries, but also that hospitals experience severe payment shortfalls when treating Medicaid patients. The AHA cited several egregious examples of states’ failure to account for the ever-increasing costs of providing care to Medicaid patients in our amicus brief on behalf of the plaintiffs in *Armstrong v. Exceptional Child Center Inc.* Examples included Pennsylvania, a state that last updated its outpatient reimbursement rates in 1991 – despite the fact that over the 23-year period from 1991 to 2014, average medical care costs more than doubled.³ On a

¹ HCUP Statistical Brief #182, October 2014.

² HCUP Fast Stats - Effect of Medicaid Expansion on Hospital Use <http://www.hcup-us.ahrq.gov/faststats/statepayer/states.jsp>

³ Brief for the American Hospital Association and the Federation of American Hospitals as Amicus Curiae, p. 8, *Armstrong v. Exceptional Child Center, Inc.*, U.S. Supreme Court decision March, 2015.

national level, the Medicaid payment shortfall amounted to \$13.2 billion in 2013,⁴ the most recent year for which data are available. This means that Medicaid paid only 90 cents for every dollar spent treating Medicaid patients – a shortfall that is in addition to the \$46.4 billion of uncompensated care hospitals provided that year to those without insurance.⁵

In the final rule, CMS acknowledges there may be other services that states should review and monitor. The agency stipulates, however, that the conditions for when states should include these services are in the case of provider rates that have been reduced or restructured, or when the state or CMS has received a higher-than-usual volume of access complaints.

This policy for additional review/monitoring is weak and grants states too much flexibility – states are cutting payments in many ways that would not trigger this provision. The Kaiser Commission on Medicaid and the Uninsured, in its most recent survey of state Medicaid programs, notes that for fiscal year (FY) 2016, 30 states are restricting inpatient hospital payments and five states are restricting outpatient hospital payments by cutting or freezing such payments.⁶ In addition, other hospital payment restrictions may slip under CMS’s radar because they would not be defined by the state as restructured payments or payment cuts, even though they have the same effect. For example:

- Changes in the Diagnosis-related Group (DRGs) payments weights that are based on average resources used to treat Medicaid patients.
- Payment delays resulting in moving a payment from one fiscal year to the next.
- Suspension of market-basket increases.

CMS also sidestepped other payments areas for further scrutiny, such as Medicaid managed care and waivers and demonstrations. With regard to Medicaid managed care, the AHA recommended in our July 23 comment to CMS that the agency require that states, on a periodic basis, study and report on how capitation rates and the subsequent managed care plan reimbursement to providers affect patient access and provider network development. By limiting this final rule to just fee-for-service payments, CMS has missed an opportunity to assess access for the nearly three-quarters of Medicaid beneficiaries who receive their care through managed care arrangements. Another area CMS is choosing not to review are new payment arrangements in the 1115 demonstration waivers. For those 1115 waiver initiatives that explore delivery system reform through innovations in provider payment, CMS should not rely on the protocols for the demonstration waivers alone to ensure payments is sufficient to ensure access. Instead, CMS should apply the final rule’s access review requirements to all these other areas.

⁴ American Hospital Association, Uncompensated Hospital Care Cost Fact Sheet, January 2015.

⁵ American Hospital Association, Underpayment by Medicare and Medicaid, Fact Sheet, January 2015.

⁶ Kaiser Commission on Medicaid and the Uninsured Survey of Medicaid Officials in 50 states and DC conducted by Health Management Associates, p 54, October 2015.

In conclusion, it is clear that greater CMS oversight is needed to help ensure that Medicaid payment cuts to hospitals do not result in access problems for the vulnerable Medicaid population.

DATA REQUIREMENTS (SECTION 447.204 (1) AND (3)). The AHA supports CMS's requirement that states' access review plans include a comparison of Medicaid provider payments to rates paid by other public and private payers to support a state's determination of sufficient beneficiary access. The AHA recommended including a comparison of Medicaid provider payment rates to other payers to more directly measure provider payment to access when we submitted our 2011 comment letter to CMS on the proposed rule. The other access review plan data requirements are: beneficiary needs; provider and care availability; beneficiary service utilization in each geographic area; and characteristics of beneficiary population (i.e., pediatric, adult and individuals with disabilities).

STANDARDS AND METHODOLOGIES (SECTION 447.204 (4)). The AHA supports CMS's requirement that states include the specific access measures they intend to use to analyze access to care in their access review plan. According to the final rule, at a minimum, states must include time and distance standards, provider participation, open provider panels, providers accepting new patients, provider feedback process and telehealth or telemedicine.

MONITORING PROCEDURES AND CORRECTIVE ACTIONS (SECTION 447.204 (6) AND (8)). The AHA supports the final rule's shorter timeframe of three years in which states must assess access after the implementation of a provider rate reduction or restructuring. The AHA recommended to CMS the shorter timeframe -- from five years to three -- as the period to monitor access after a payment rate reduction in our 2011 comment letter on the proposed rule.

The AHA supports the requirement in the final rule that states must address access deficiencies within 90 days after discovery, including submitting a corrective action plan with specific steps and timelines. Specifically, CMS instructs the states that remediation efforts to address access deficiencies should take place within 12 months of the initial reports. CMS provides examples for states on how access deficiencies could be addressed including increasing payment rates which clearly acknowledges the important link between provider payment rates and beneficiary access. The agency also suggests that states could address access deficiencies by improving outreach to providers, reducing barriers to provider enrollment, providing transportation services, providing for telemedicine or telehealth, or improving care coordination. In the end, CMS is granting states so much flexibility in deciding to address access deficiencies that this corrective action requirement may have little meaning.

BENEFICIARY AND PROVIDER ENGAGEMENT (SECTION 447.204 (7)). The final rule requires that states implement ongoing mechanisms for beneficiary and provider input on access to care (e.g., through hotlines, surveys, an ombudsman or equivalent mechanisms).

Further, the rule requires that states promptly respond when access problems are identified with an appropriate investigation, analysis and response. States must maintain a record of public input and the state's response must make that record available to CMS upon request. **The AHA believes that an ongoing mechanism to engage beneficiaries and providers regarding access to care is an important oversight measure. We also believe requiring states to maintain documentation of public input regarding access deficiencies and the state's response to these deficiencies is a good accountability measure. To strengthen these accountability requirements, the AHA recommends that such documentation be included in any state plan amendment seeking changes in provider payment that has been submitted by the state for CMS approval.**

PUBLIC NOTICE AND STATE PLAN AMENDMENT AFFECTING PAYMENT RATES

PUBLIC NOTICE (SECTION 447.205). States are required to provide public notice of changes in methods and standards for setting payment rates. To meet this requirement, the state may post the notice on the state Medicaid agency's website. **The AHA believes this public notice is critical to an open and transparent rate-setting process.** Such notice requirements mean little, however, if the beneficiaries and stakeholders do not have the benefit of the state's analysis of provider rates and determination of how access may or may not be affected. **The AHA recommends that, to make this this public notice process more meaningful, CMS require that detailed analysis of the access review and provider payment data be made public in the most accessible manner possible.**

STATE PLAN AMENDMENTS (SPAS) (SECTION 447.204). The AHA supports the final rule requirements that states must include key information that affect provider payment rates when the states submits an SPA to CMS for approval. Included in those requirements are: the most recent access plan; analysis examining the effect of changes in payment rates on access; and analysis of information and concerns expressed by stakeholders. This additional information will be key to CMS's oversight of state provider payments rates and the link to beneficiary access to needed health care services.

Medicaid enrollment is growing; along with this growth, there will be increases in health utilization, including hospital services. The Medicaid and CHIP Payment and Access Commission (MACPAC) reports that in 2014, 78.6 million people relied on the Medicaid program for their health care, including our nation's most vulnerable children, poor, disabled and elderly.⁷ By 2020, the Medicaid program will add 14 million more to its rolls as a result of the Affordable Care Act-related coverage.⁸ In light of the continuing

⁷ MACPAC, MACTStats: Medicaid and CHIP Data Book, December 2015 p. 2.

⁸ Congressional Budget Office, March 2015 Baseline estimates of Insurance Coverage Provisions of the Affordable Care Act.

fiscal pressures and expanding numbers of people to serve, state governments will continue to turn to reforms in provider payment and care delivery systems to address these pressures. Hospitals understand the need to provide patient care in a more accountable, more coordinated way and that they will be expected to improve outcomes for patients while lowering costs. That is why it is so crucial to ensure there are proper and necessary oversight tools for allowing CMS to hold states accountable in how they set their Medicaid provider payment rates and maintain beneficiary access to health care services.

In conclusion, for hospitals, the final rule falls short because it excludes all hospital services (except labor and delivery) as a core service subject to the state access review plans. If CMS intends to meaningfully hold states accountable for meeting the statutory requirements that provider payments should be sufficient to ensure beneficiaries access to care, the AHA believes this final rule must be either revised or reissued. Anything short of this would mean that CMS is failing to create meaningful oversight of state provider payments to ensure sufficient access to services for the vulnerable populations served by the Medicaid program.

Thank you for your consideration of our comments. If you have any questions, please contact me or Molly Collins Offner, director of policy development, at (202) 626-2326 or mcollins@aha.org.

Sincerely,

/s/

Thomas P. Nickels
Executive Vice President